**PPO provisions apply whether MAP is the primary or secondary plan.**

**An Example**
Assume you live in a PPO area. You have met your deductible and QCP pre-certified a 4-day hospital stay.

PPO Hospital
In a PPO hospital, all covered hospital charges are paid in full.

Non-PPO Hospital
- You are not Medicare eligible.
- The non-PPO hospital charges $3,500 for your stay
- The PPO area PA is $2,100.

Here's what MAP would pay for this Non-PPO stay.

| **Non-PPO Hospital Charges** | | **$3,500** |
|---|---|---|
| **MAP Would Pay** | 90% of PA | 90% x $2,100 = $1,890 |
| **You Would Pay** | Hospital charge minus benefit | $3,500 – $1,890 = $1,610 |
| **Applies to Out-of-Pocket Limit** | PA minus benefit | $2,100 – $1,890 = $ 210 |
| **Does Not Apply to Out-of-Pocket Limit** | Hospital charge minus PA | $3,500 – $2,100 = $1,400 |

In the example, you would pay $1,610. Only 10% of the PA, which is $210, applies to the out-of-pocket limit. The remaining $1,400 above PA is not a covered expense and does not apply to the out-of-pocket limit.

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**Remember, the choice of which hospital to use is up to you and your physician. You make the decision each time you require hospitalization.**

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SPECIAL LIMITATIONS

**Treatment Of Mental/Nervous Conditions**
Partial hospitalization for substance abuse or treatment of an inpatient mental/nervous condition must have QCP pre-certification. There are other limitations on mental/nervous care benefits. Refer to Section 9 for more information.

**Diagnostic X-Rays/Laboratory Tests, Physical Therapy**
If you enter a hospital on an inpatient basis primarily for diagnostic X-rays/laboratory tests or physical therapy, no benefits will be paid toward your room and board charges. These charges are not covered expenses and will not apply toward your deductible or out-of-pocket limit since diagnostic tests and physical therapy should be provided on an outpatient basis.

The expenses for services other than room and board will be covered in the same manner as Outpatient Hospital benefits, subject to PPO provisions.

**Weekend Admissions**
If you are admitted to the hospital on a Friday or Saturday for a non-emergency condition, weekend room and board charges will not be pre-certified, and MAP will not cover them unless, on the day you are admitted **1)** you have surgery, or **2)** you have a condition that requires hospitalization for medically necessary tests and surgery is performed on the following day.

**Rehabilitative/Custodial Expenses**
Hospital room and board and ancillary charges are not covered when the admission is custodial or primarily for rehabilitative care that can be provided on an outpatient basis.

**Dental Care**
Hospitalization for dental care is covered only when:

- Confinement results from accidental bodily injury, **or**
- A physician, other than a dentist, pre-certifies through QCP that hospitalization is necessary, due to a non-dental organic impairment, to safeguard the patient's life/health.

No hospitalization benefits are paid for surgical removal of impacted teeth unless there is an underlying medical condition requiring confinement.

Covered dental hospitalization benefits are the same as medical/surgical hospitalization benefits described in this section.

OUTPATIENT HOSPITAL BENEFITS
Covered charges for non-emergency services from an ambulatory surgical facility or an outpatient department of a hospital are paid as follows, after the deductible (see exceptions below):

- PPO hospital benefits are paid at 100% of covered charges.
- If you live in a PPO area, non-PPO hospital benefits are paid at:
  - 90% of PA, including outpatient surgery, unless the charges are for pre-admission or pre-surgical X-rays or tests, **or**
  - 100% of PA for pre-admission or pre-surgical X-rays or tests (as described below).
- If you do not live in a PPO area, non-PPO hospital benefits are paid at:
  - 90% of covered charges, including outpatient surgery, unless the charges are for pre-admission or pre-surgical X-rays or tests; or
  - 100% of covered charges for pre-admission or pre-surgical X-rays or tests.
- If you are a Medicare-primary participant, benefits will be paid at 100% of covered charges less the benefit paid by Medicare whether you use a PPO or non-PPO hospital.

**Note: Covered charges for services/surgery performed at a free-standing clinic are paid as if the services were performed in a physician's office. If the clinic is located on the grounds of a PPO hospital and is part of the PPO Agreement, PPO benefits would apply.**

The deductible is not required for the following:

- Facility charges for outpatient surgery
- Accidental injury and sudden/serious illness when treated within 72 hours
- Pre-admission or pre-surgical X-rays or tests

For services to be considered pre-surgical tests for outpatient surgery or pre-admission tests, all of the following criteria must be met:

- The tests must be necessary and consistent with the diagnosis and treatment of the condition
- The patient must be physically present for the test
- The tests must not be performed to determine whether hospital care is necessary
- The admission or scheduled outpatient surgery must not be canceled or postponed except as a result of a second surgical opinion or other medical reason
- In the case of pre-admission tests, a hospital bed must be reserved before the tests are performed, and the admission date must be such that the tests would be medically valid for the treatment

If tests are duplicated after admission, the tests performed prior to admission will not be covered.

**Note: If complications resulting from outpatient services require admission as an inpatient, all facility charges will be considered at inpatient MAP benefit levels. This admission will be subject to all PPO provisions and QCP penalties.**

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**Remember, the decisions regarding treatment are up to you and your physician.**

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## SECTION 8. PHYSICIAN/SURGEON CARE BENEFITS

Where it is economically feasible, and sufficient physicians elect to participate, MAP will continue to implement physician PPOs. You should contact QCP to determine whether a PPO physician network has been established in your area. If Medicare is primary, PPO physician provisions do not apply.

### OFFICE VISITS

Benefits for office visits are paid as follows:

- PPO physician services will be paid at 90% of covered charges, no deductible, after a $5 copayment.
- If you live in a PPO area, non-PPO physician services will be paid at 80% of PA after the deductible, even if MAP is the secondary plan.
- If you do not live in a PPO area, non-PPO physician services will be paid at 90% of R&C after the deductible.

Office visits and services for routine health check-ups or examinations are not covered under MAP unless specifically stated as being covered.

### HOSPITAL VISITS, SURGERY, ANESTHESIA ADMINISTRATION

Benefits for covered charges are as follows:

- PPO physician services will be paid at 90% of covered charges, no deductible required.
- If you live in a PPO area, non-PPO physician services will be paid at 80% of PA after the deductible.
- If you do not live in a PPO area, non-PPO physician services will be paid at 90% of R&C after the deductible.

Covered charges include one hospital visit per day by your primary physician. Inpatient consultations by physicians other than your primary physician are limited to one consultation for each specialty, per admission. (Benefits for emergency physician care are explained on page 34.)

For substance abuse rehabilitation, inpatient physician charges which are not part of the program and are not billed by the facility are not covered.

### SURGERY

When medically necessary, MAP also provides benefits for an assistant surgeon at the same level as those provided for the surgeon. MAP does not cover surgical assistants who are not licensed medical doctors.

**Surgical Benefits For Multiple Procedures Performed During The Same Operative Session**

When two or more surgical procedures are performed during the same operative session, the surgeon's time pertaining to the treatment of the patient is not increased two-fold. The medical visits leading up to the actual surgery, the preparation of the patient, and the post-operative medical visits associated with the surgery are included in determining the R&C allowance. The physician generally renders the same amount of follow-up medical care for two or more surgical procedures as for one. That is why many physicians charge less for a procedure when it is performed as a secondary procedure than when it is performed as a single surgery. That is also why MAP's benefit levels are unique for multiple procedures performed during the same surgical session.

MAP's intent is not to penalize the patient for having more than one procedure performed. This provision is

than the R&C charge for the more expensive procedure and 50% of the R&C charge for the less expensive procedure(s).

- Bilateral procedures (i.e., removing cataracts from both eyes) performed during the same operative session in separate operative fields are covered up to the surgeon's R&C charge for the total procedure up to 150% of R&C for the unilateral procedure.

For the multiple surgical procedures listed below . . .

- Cesarean-section with tubal ligation
- Vaginal delivery with tubal ligation
- Hysterectomy with appendectomy
- Laparotomy with dilation and curettage

. . . MAP benefits will be determined as follows:

- Multiple surgical procedures during the same operative session performed through the same incision or in the same operative fields are covered up to the surgeon's R&C for the most expensive procedure, and 50% of R&C for the other procedures.
- Multiple surgical procedures performed during the same operative session through separate incisions and in separate operative fields are covered up to the surgeon's R&C for the total procedure, but not more than the R&C for the more expensive procedure, and 75% of the R&C charge for the less expensive procedure(s).

**MATERNITY**
For coverage information on maternity-related expenses, see pages 34-35.

**CHIROPRACTIC SERVICES**
MAP pays 90% of R&C up to a $100 benefit for the first covered visit (one per lifetime) processed under MAP, and up to a $50 benefit for subsequent visits. The first visit normally includes X-rays, an examination, and the determination of treatment.

Covered charges are limited to two visits each calendar week and 20 visits each calendar year. Charges above these limits do not apply to the deductible or out-of-pocket limit.

**OUTPATIENT SURGEON'S CHARGES**
Benefits for all outpatient surgeon's charges, including charges for procedures listed on the Mandatory Outpatient Surgical Procedures List (below), are as follows:

- PPO physician services will be paid at 90% of covered charges, no deductible required.
- If you live in a PPO area, non-PPO physician services will be paid at 80% of PA after the deductible.
- If you do not live in a PPO area, non-PPO physician services will be paid at 90% of R&C after the deductible.

For benefits when more than one surgery is performed during the same operative session see "Surgical Benefits For Multiple Procedures Performed During The Same Operative Session" (page 25).

## Mandatory Outpatient Surgical Procedures List

| Procedure | Description |
|---|---|
| Dilation and Curettage | Dilation and scraping of uterus |
| Excision of lesions of skin subcutaneous and soft tissue (malignant/benign) | Removal of cysts, tumors, lipomas, etc. |
| Eye muscle operations | Surgery to correct muscle imbalance |
| Hammertoe repair | Surgery to correct congenital deformity of toes |
| Hemorrhoidectomy | Removal of hemorrhoids |
| Herniorrhaphy | Hernia repair |
| Mastoidectomy | Removal of part of mastoid process |
| Neuroplasty | Surgery on nerves/nerve tissue |
| Submucous resection | Partial excision of nasal septum |
| Tendon (sheath) release/repair | Incision or repair of tendons |
| Varicose vein ligation* | Surgery on enlarged veins |

*This procedure requires a second surgical opinion and must be pre-certified by QCP.

### MANDATORY OUTPATIENT SURGICAL PROCEDURES PERFORMED ON AN INPATIENT BASIS

MAP will cover inpatient expenses for procedures listed above only when pre-certified by QCP that it is medically necessary to have the procedure performed on an inpatient basis or that there is no outpatient facility within 25 miles of your home. If a mandatory outpatient procedure is performed on an inpatient basis without QCP pre-certification, MAP will cover only the expenses that would have been paid if the procedure had been performed on an outpatient basis.

### SURGICAL OPINIONS

When you or a covered dependent need surgery, and the procedure is on the Mandatory Second Surgical Opinion List (see page 28), contact QCP. QCP will review your medical circumstances and determine if a second surgical opinion is required or if it can be waived as a condition to receiving maximum MAP benefits.

If you do not obtain the required second opinion, and you proceed with surgery, the QCP Penalty will be applied. If QCP waives the second opinion, and you still obtain one, it will not be covered.

When a required second opinion does not agree with your physician's recommended treatment, the following options are available to you:

- You, your physician, or a family member may contact QCP to discuss alternatives to surgery.
- You may contact QCP to obtain a third opinion from another physician by following the same procedure as for a second opinion. The same benefit levels will apply.
- You may choose not to obtain a third opinion and proceed with the surgery but,
  - If Blue Cross and Blue Shield of Alabama determines that the surgery was not medically necessary, the expenses will not be covered, or
  - If determined to be medically necessary, your MAP payment will be subject to the QCP Penalty.

When a required third opinion does not confirm the need for surgery, and you proceed with the surgery:

- If Blue Cross and Blue Shield of Alabama determines that the surgery was not medically necessary, the expenses will not be covered, or
- If determined to medically necessary, your MAP payment will be subject to the QCP Penalty.

If you choose to proceed with surgery on an inpatient basis when there is no confirming opinion, and QCP does not certify the confinement, more than one QCP Penalty will be applied.

* * * * * *

**Remember, it is up to you and your physician whether or not you have the surgery.**

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## SURGICAL OPINION PAYMENTS

MAP pays for required second or third surgical opinions as follows:

- If a QCP-listed physician is used, the opinion is paid in full

## SECTION 9. MENTAL AND NERVOUS CARE BENEFITS

For purposes of MAP, the term "mental/nervous" includes alcoholism and drug addiction, referred to in this booklet as substance abuse.

### BENEFIT LIMITATIONS

MAP will pay an individual lifetime maximum benefit of up to $150,000 for covered expenses due to inpatient, partial hospitalization, and outpatient mental/nervous care. Once a participant reaches this limit, additional mental/nervous expenses will not be covered and will not count toward the participant's deductible or out-of-pocket limit.

MAP pays for two substance abuse rehabilitation benefits per lifetime: one inpatient benefit and one partial hospitalization benefit. To be considered separate, the second benefit must start at least 180 days after the first one ends.

In addition, specific benefits have special limits as described in this Section.

### Special Rules For PPO And Non-PPO Hospital Benefits

Lower benefit levels will be paid for non-PPO hospital charges that are incurred in a PPO area, regardless of where the participant lives. This rule applies to all mental/nervous confinements, including confinements for substance abuse. In other words, if you live outside the PPO area, but receive treatment within a PPO area, you must use a PPO facility to obtain maximum MAP benefits.

Benefits for Medicare-primary participants are the same as the PPO hospital benefits, whether or not a PPO hospital is used.

The amount you pay does not apply to the out-of-pocket limit. In addition, once the out-of-pocket limit is reached, benefits will not increase to 100%.

### INPATIENT BENEFITS

All inpatient confinements for mental/nervous conditions (including those for Medicare-primary participants) must be pre-certified by QCP. If QCP does not certify the admission, the inpatient expenses are not covered and do not apply toward the out-of-pocket limit.

Mental/nervous confinements will be reviewed to determine the portion of care that is medically necessary versus that which is maintenance or custodial and not covered under MAP.

**Hospital Benefits: Substance Abuse Care**
Once certified by QCP, benefits are paid as follows after the deductible has been met:

- 100% of covered inpatient hospital charges from a PPO hospital
- 90% of the PPO area PA for covered inpatient hospital charges from a non-PPO hospital located inside a PPO area
- 100% of covered inpatient hospital charges from a non-PPO hospital if the participant does not live in a PPO area, and the hospital is not located in a PPO area

**Inpatient Detoxification Benefits**
MAP covers hospital and physician charges for up to 30 days for each detoxification benefit. No more than 2 detoxifications during a 5-year period are covered. The second benefit must start at least 180 days after the first one ended to be considered separate.

**Inpatient Substance Abuse Rehabilitation Benefits**
MAP covers hospital charges for one inpatient rehabilitation program per lifetime for up to 30 days for active and retired employees, surviving spouses and Class I dependents. Class II and sponsored dependents are not eligible for this benefit. Any fees, including physician fees, separately billed from the inpatient facility program charge are not covered under MAP.

**PARTIAL HOSPITALIZATION/SUBSTANCE ABUSE REHABILITATION PROGRAM BENEFITS**
(ALTERNATE BENEFIT)
"Partial hospitalization" is when a patient is admitted to the hospital under an approved treatment or rehabilitation program and the daily stay is for less than 24 hours. To be eligible for reimbursement under MAP, QCP must pre-certify partial hospitalization.

Expenses from an approved day or evening rehabilitation program are paid as follows:

- 100% of covered charges from a PPO hospital, deductible required
- If you live in a PPO area, non-PPO hospital at 90% of PA, deductible required
- If you do not live in a PPO area, non-PPO hospital at 100% covered charges, deductible required

Benefits are limited to one partial hospitalization per lifetime up to 30 treatment days.

An approved partial hospitalization/substance abuse rehabilitation program is one that is:

- Approved by the Joint Commission on Accreditation of Health Care Organizations
- Usually four to six weeks in duration, either day or evening
- Specifically designed for the treatment of addictions
- Specifically tailored to address the problem of substance abuse

**OUTPATIENT MENTAL/NERVOUS BENEFITS**
Once the deductible is met, MAP pays physicians fees at 90% of R&C up to $50. In addition, MAP limits this benefit to 2 visits each calendar week, not to exceed 52 visits per calendar year. Services must be provided by a Doctor of Medicine (M.D.) or an individual who possesses a Doctorate degree (Ph.D., Ed.D. or Psy.D.) and is licensed and certified as a clinical psychologist. Services provided by a social worker or counselor are not covered under MAP.

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**Remember, all mental/nervous treatment decisions are up to you and your physician.**

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## SECTION 10. PRESCRIPTION DRUG BENEFITS

Under MAP, you have three options for obtaining prescription drug benefits. You may purchase your prescription drugs from:

- The Mail Order Prescription Drug Program
- PPO pharmacies
- Any pharmacy, and submit a Prescription Drug Claim Form to Blue Cross and Blue Shield of Alabama

To maximize your benefits, you should always purchase generic drugs when permitted by your physician.

**GENERIC AND BRANDNAME DRUGS**
A generic drug is one that uses its chemical name. The brandname is the trade name under which the drug is advertised and sold. By law, generic and brandname drugs must meet the same standards for safety, purity, strength and effectiveness. When authorized by your physician and permitted by applicable law, a pharmacy is able to dispense a generic drug. You will find that using generic drugs will save you money.

**NON-COVERED OVER-THE-COUNTER AND LEGEND DRUGS**
Drugs that may be purchased without a prescription (over-the-counter) are not covered by MAP–even if your physician "prescribes" them–except for prenatal vitamins.

Certain "legend" drugs, obtained by prescription only, are considered exclusions and are never covered under MAP. These include, but are not limited to:

- Investigational drugs
- Infertility drugs
- Nicorette/Nicoderm or any smoking cessation drug/supply
- Vitamins (except prenatal)
- Drugs for the purpose of weight loss

Other prescription drugs are covered only when supported by documentation of medical necessity. These drugs include, but are not limited to: Accutane/Retin-A, oral contraceptives, growth hormones, and cosmetic chemotherapy.

Syringes are covered only under the Mail Order Prescription Drug Program. A prescription is required, and the participant must pay a $7 copayment for up to a 90-day supply.

**THE MAIL ORDER PRESCRIPTION DRUG PROGRAM**
If you take prescribed drugs on a regular or maintenance basis, you may order the medication through this program. Your covered dependents may use this program only if:

- MAP is their primary plan, **or**
- Primary coverage is provided by Medicare, and MAP is the secondary plan.

Rules for determining when MAP is the primary plan are explained in Section 12.

**How The Program Works**
The Mail Order Prescription Drug Program is administered by National Rx Services, Inc., a subsidiary of Medco Containment Services, Inc. Through this program, no deductible is required. Your copayment for each covered

prescription is $7. National Rx Services, Inc. will fill your covered prescriptions only for the amount prescribed by your physician–up to a 90-day supply. For certain controlled substance drugs, the amount dispensed may be less than the amount prescribed by your physician. Your medication will be mailed to you via U.S. Mail or United Parcel Service (UPS) along with instructions for future refills. For each drug, your first order will require a "new"/original prescription. Refill prescriptions originally filled by another pharmacy are unacceptable.

All prescription orders will be filled with a generic drug when a generic substitution is available and permissible by law, unless your physician requires the use of a brandname drug. However, if the prescription is for a brandname drug, and a generic is available and allowed by your physician, but you choose the brandname drug, you must pay the difference in cost between the brandname drug and generic drug plus the $7 copayment. National Rx Services, Inc. will notify you of the additional cost and the method for paying.

**Your Cost**
Your cost for each prescription drug is either a $7 copayment or a $4 copayment plus a $3 coupon.

When a generic drug is sent to you, a $3 coupon will be included with your order. This $3 coupon may be used as a credit against the required $7 copayment for your next prescription order or refill. Only one coupon may be used for each drug; therefore, you will always pay at least $4 for each prescription drug ordered. BellSouth pays the remainder of the covered drug cost plus all administrative costs of this program.

Copayments for the Mail Order Prescription Drug Program do not apply to the deductible or out-of-pocket limit and may not be reimbursed under MAP. These copayments are always required—even if the out-of-pocket limit has been reached.

**How To Order A Prescription Drug**
To order a prescription drug, simply mail your "new"/original prescription(s), your completed Prescription Order Claim Form, and the appropriate copayment(s) in a pre-addressed envelope to National Rx Services, Inc.

Prescription drug order inquiries or requests for National Rx Services, Inc.'s Prescription Order Forms should be directed to the Customer Service Department **1-800-447-7856**, Monday through Friday between 8 a.m. and 8 p.m., or Saturday from 8 a.m. to Noon, Eastern Standard Time (EST).

**PREFERRED PROVIDER ORGANIZATION (PPO) PHARMACIES**
A PPO network of pharmacies has been developed to provide prescription drugs to MAP primary-covered and Medicare-primary/MAP-secondary participants. You may call Blue Cross and Blue Shield of Alabama for the names of the participating pharmacies near you.

**PPO Pharmacy Benefits**
You have the option of purchasing covered prescription drugs from a PPO pharmacy for a copayment of $10 for each prescription for up to a 30-day supply. If the prescription is for a brandname drug, and a generic is available and allowed by your physician, but you choose the brandname drug, you must pay the difference in cost between the brandname drug and generic drug. No deductible or claim form is required.

If the cost of the drug is less than $10, your payment will be the cost of the drug. In this case, you may file a claim for the cost of the drug with Blue Cross and Blue Shield of Alabama for general prescription benefits.

Copayments for the PPO pharmacies do not apply to the deductible or out-of-pocket limit and may not be reimbursed under MAP. These copayments are always required -- even if the out-of-pocket limit has been reached.

## GENERAL PRESCRIPTION DRUG BENEFITS

You may choose to submit your covered prescription expenses to Blue Cross and Blue Shield of Alabama for reimbursement. After the deductible has been satisfied, MAP will pay 90% of R&C for generic drugs or for brandname drugs when required by your physician. Should you elect to purchase a brandname drug when a generic drug is available and permitted by your physician, MAP reimburses at the average generic price. Therefore, your reimbursement could be substantially lower than the cost of the brandname drug.

To receive MAP benefits, you must submit a completed Medical Plan Prescription Drug Claim Form to Blue Cross and Blue Shield of Alabama along with the purchase receipts. See Section 14, How To File A Claim.

## SECTION 11. ADDITIONAL PLAN PROVISIONS

**Remember, to maximize your benefits you should use a PPO physician/hospital whenever possible.**

### ACCIDENTAL INJURY AND SUDDEN/SERIOUS ILLNESS

If you or a covered dependent have an accidental injury or a sudden/serious illness, MAP covers the related facility and physician charges as follows:

### EMERGENCY CONDITIONS

Conditions resulting in hospitalization, bone fractures, abrasions, lacerations, poisoning, rape or sudden/serious illness.

**Facility Charges**

If you are treated within 72 hours of occurrence, facility charges will be paid in full with no deductible.

**Physician/Surgeon Charges**

- PPO physician charges will be paid at 90% of covered charges.
- Non-PPO physician charges will be paid at 90% of R&C.

### NON-EMERGENCY CONDITIONS

**Facility Charges**

When you use an emergency room for non-emergency conditions or accidental injury and sudden/serious illness treated after 72 hours of occurrence, there are no benefits for the emergency facility fee.

The remaining covered charges for ancillary fees, such as lab, x-ray, etc., will be paid as follows:

- PPO hospital services will be paid at 100% of covered charges after a $25 copayment, deductible required.
- If you live in a PPO area, non-PPO hospital covered charges will be paid at 90% of PA after a $50 copayment, deductible required.
- If you do not live in a PPO area, non-PPO hospital covered charges will be paid at 90% of the covered charges after a $25 copayment, deductible required.

Copayments for non-emergency conditions do not apply to the deductible or out-of-pocket limit.

**Physician/Surgeon Charges**

Physician/surgeon charges will be paid at normal physician benefit levels with the PPO provision applied. (See Section 8.)

If the emergency/non-emergency condition requires hospitalization and the admission is approved by QCP, MAP pays benefits as described in Sections 7 and 8, Hospital Care Benefits and Physician/Surgeon Care Benefits.

### MATERNITY CARE

It is required that you contact QCP for pre-certification during the first trimester of pregnancy. This will allow QCP to assist employees in maximizing their benefits and lowering their out-of-pocket expenses.

QCP also administers the Happy Healthy Babies Program that provides a voluntary health risk screening for pregnant MAP participants.

The obstetrician's global fee for prenatal and postnatal care is paid as follows:

- PPO physician services will be paid at 100% of covered charges, no deductible required.
- If you live in a PPO area, non-PPO physician services will be paid at 80% of PA, no deductible required.
- If you do not live in a PPO area, non-PPO physician services will be paid at 100% of R&C, no deductible required.

Coverage for nurse midwives is provided under Alternate Benefits and must be pre-certified by QCP (see Section 6, page 19).

*Prenatal vitamins are covered by MAP up to Well Child Care annual limits.*

If you are considering a sterilization procedure following your child's delivery, see the Multiple Surgical Procedure provisions on page 25. Inpatient hospital expenses for maternity care are covered as any other illness or injury (see Section 7). **Remember, because maternity admissions are not considered emergencies, you must contact QCP for pre-certification.**

**Well Baby Pediatric Examination**
MAP pays benefits for one "well baby" pediatric examination of a newborn child during the mother's hospital confinement.

- PPO physician services will be paid at 90% of covered charges, no deductible required.
- If you live in a PPO area, Non-PPO physician services will be paid at 80% of PA, no deductible required.
- If you do not live in a PPO area, non-PPO physician services will be paid at 90% of R&C, no deductible required.

*Routine nursery charges are covered under the Hospital Care Benefits provisions of MAP with no deductible required (see Section 7).*

WELL CHILD CARE
MAP covers routine exams and immunizations to age 6 and annual screenings for ages 6 through 12 up to $250 per child and $400 per family during any calendar year. Amounts not paid due to the annual limit being met and the $5 copayment do not apply to the deductible or out-of-pocket limit.

- PPO physician services will be paid at 90% of covered charges after a $5 copayment, no deductible required.
- If you live in a PPO area, non-PPO physician services will be paid at 80% of PA after a $5 copayment, no deductible required.
- If you do not live in a PPO area, non-PPO physician services will be paid at 90% of R&C after a $5 copayment, no deductible required.

MAMMOGRAPHY
**For women under age 40**, mammograms for a diagnosed condition are covered under MAP as follows:

- PPO physician services will be paid at 90% of covered charges, no deductible required.
- If you live in a PPO area, non-PPO physician services will be paid at 80% of PA after the deductible.
- If you do not live in a PPO area, non-PPO physician services will be paid at 90% of R&C after the deductible.

Prior to age 40, routine mammogram screenings are not covered.

**For women ages 40-49,** the first mammogram performed either due to a diagnosed condition or a routine screening is paid as follows:

- PPO physician services will be paid at 100% of covered charges, no deductible required.
- If you live in a PPO area, non-PPO physician services will be paid at 80% of PA, no deductible required.
- If you do not live in a PPO area, non-PPO physician services will be paid at 100% of R&C, no deductible required.

Subsequent mammograms are covered only if performed for a diagnosed condition and will be paid as follows:

- PPO physician services will be paid at 90% of covered charges, no deductible required.
- If you live in a PPO area, non-PPO physician services will be paid at 80% of PA after the deductible.
- If you do not live in a PPO area, non-PPO physician services will be paid at 90% of R&C after the deductible.

**For women age 50 and over,** one mammogram per calendar year performed either for a diagnosed condition or as a routine screening is covered as follows:

- PPO physician services will be paid at 100% of covered charges, no deductible required.
- If you live in a PPO area, non-PPO physician services will be paid at 80% of PA, no deductible required.
- If you do not live in a PPO area, non-PPO physician services will be paid at 100% of R&C, no deductible required.

Within that year, subsequent mammograms for a diagnosed condition will be paid as follows:

- PPO physician services will be paid at 90% of covered charges, no deductible required.
- If you live in a PPO area, non-PPO physician services will be paid at 80% of PA after the deductible.
- If you do not live in a PPO area, non-PPO physician services will be paid at 90% of R&C after the deductible.

**PHYSICIAN X-RAY AND LAB BENEFITS**
Covered X-ray and lab services are paid as follows:

- PPO physician services will be paid at 90% of covered charges, no deductible required.
- If you live in a PPO area, non-PPO physician services will be paid at 80% of PA after the deductible.
- If you do not live in a PPO area, non-PPO physician services will be paid at 90% of R&C after the deductible.

However, if X-ray and lab services are performed for pre-admission or pre-surgical testing, the benefits are as follows:

- PPO physician services will be paid at 100% of covered charges, no deductible required.
- If you live in a PPO area, non-PPO physician services will be paid at 100% of PA, no deductible required.
- If you do not live in a PPO area, non-PPO physician services will be paid at 100% of R&C, no deductible required.

**PAP SMEARS**
The laboratory fee is paid as follows:

- PPO hospital services are paid at 100% of covered charges, no deductible required.
- If you live in a PPO area, non-PPO hospital services are paid at 100% of PA, no deductible required.

- If you do not live in a PPO area, non-PPO hospital services are paid at 100% of covered charges, no deductible required.

Physician charges are paid as follows:

- PPO physician services are paid at 100% of covered charges, no deductible required.
- If you live in a PPO area, non-PPO physician services are paid at 80% of PA, no deductible required.
- If you do not live in a PPO area, non-PPO physician services are paid at 100% of R&C, no deductible required.

**CHEMOTHERAPY, ELECTROSHOCK, AND RADIATION THERAPY**

MAP covers the cost of chemotherapy, electroshock and radiation therapy (for the agent/drug and its administration but not the hospital charges) with no deductible required. The agent/drug is paid at 100% of R&C.

Physicians' administration charges are paid as follows:

- PPO physician services will be paid at 100% of the covered charges, no deductible required.
- If you live in a PPO area, non-PPO physician services will be paid at 80% of PA, no deductible required.
- If you do not live in a PPO area, non-PPO physician services will be paid at 100% of R&C, no deductible required.

**HUMAN ORGAN TRANSPLANTS**

MAP coverage for human organ transplants is provided only under the circumstances described in this section and is limited to the following procedures:

- Bone marrow
- Cornea
- Heart
- Kidney

Bone marrow, heart, and kidney transplants must meet all of the following criteria before being covered under MAP:

- The patient must have no other terminal disease requiring treatment that would not be affected by the transplant
- The procedure must be performed in approved facilities which have demonstrated a high degree of success. The names of these facilities are available from QCP
- The patient must satisfy the selection criteria of the facility to which he/she has been referred

In addition, bone marrow and heart transplants must meet all of the following requirements before they will be covered under MAP:

- The patient must be faced with a life-threatening illness, and all alternative conventional therapies must have been performed without having cured or lessened the medical situation
- The transplant must have a reasonable probability of success which will lead to a higher quality of life

Subject to the foregoing requirements, autologous bone marrow transplants are covered under MAP for only the following conditions:

- Advanced Hodgkin's Disease in individuals for whom conventional treatment has failed and who have no compatible donor
- Acute leukemia in remission in individuals who have a high probability of relapse and no compatible donor
- Specific resistant non-Hodgkin's lymphomas

Certain transplants not covered under MAP may be eligible for benefits if the participant elected coverage under the Supplemental Transplant Assistance Plan (STAP). Contact QCP for more information.

**ADDITIONAL MAP BENEFITS**

MAP pays 90% of the R&C charges once the deductible has been met for the following:

- Physical therapy/physiotherapy, if prescribed by a physician and performed by a registered physical therapist (RPT), or when performed by a licensed physical therapy assistant (LPTA) when supervised and billed by an RPT
- Blood, if not donated or otherwise replaced
- Initial placement of artificial limbs and eyes, but not their replacements
- Certain prescribed durable medical equipment, e.g., wheelchairs
- Local ambulance service to the nearest hospital where treatment is first given (benefits increase to 100% for a transfer from a non-PPO hospital to a PPO hospital when pre-certified by QCP)
- Private duty nursing, if pre-certified by QCP; however, the following criteria apply:
  - Expenses incurred for the professional services of a registered nurse (RN) or a licensed practical nurse (LPN)–other than a nurse who is a member of the immediate family and resides in the covered individual's home–may be covered, **and**
  - Payment will be made for only that portion of the nurse's services that are determined to be medically necessary and then only upon receipt of a physician's written documentation of such need. A listing of the special care services should be provided.

**EXCLUSIONS (NOT COVERED UNDER MAP)**

Although MAP covers a broad range of services and supplies, there are some items, as in all plans of this type, that are excluded and are not covered. These include but are not limited to:

- Saturday and Sunday hospital room and board charges for non-emergency Friday and Saturday admissions, except as explained on page 34
- Expenses due to a pre-existing condition, (see page 16)
- Charges for any services received before coverage under MAP began
- Expenses due to an occupational illness or injury covered by Workers' Compensation (see page 2)
- Routine health check-ups or examinations unless specifically stated under MAP's provisions
- Diagnostic tests (unless specifically stated under MAP's provisions) which do not reveal either an illness or injury, unless you submit satisfactory proof that you had specific symptoms of a condition requiring medical attention
- Charges paid or payable under the laws of any country or for which you have no legal obligation to pay
- Brandname prescription drug charges in excess of the cost for generic drug substitutes when a generic drug is available and allowed by the prescribing physician

- Over-the-counter drugs, even if prescribed, except prenatal vitamins
- Charges in excess of R&C limits

MAP is intended to reimburse you for medically necessary expenses incurred for the care and treatment of a non-occupational illness or injury. Therefore, any charges for care, treatment, services or supplies that are not determined to be medically necessary for the treatment of a non-occupational illness or injury or which are provided solely for your convenience are considered exclusions and will not be covered by MAP.

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**Remember, you and your physician are responsible for making all decisions regarding your medical treatment.**

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## SECTION 12. COORDINATION OF BENEFITS

With the growing number of medical plans and the increasing number of two-income families, many people are covered or have the opportunity to be covered under more than one group plan. For this reason, MAP contains a Coordination of Benefits (COB) provision which is designed to ensure benefits up to your MAP benefit levels on each claim while preventing duplication of payment.

COB applies when an employee or dependent is covered, or in certain circumstances eligible for coverage, by more than one group plan or by Medicare (see Section 13). Under MAP, a group plan is a medical plan offered by an employer (business, partnership, individual owner, etc.) to its employees at no cost or at a cost subsidized by the employer. For example, multiple-choice, flexible benefit plans, ERISA-type plans, federal/state/local government plans, and certain church plans are considered group plans.

If an employer simply offers a plan for the convenience of its employees by collecting the premiums but does not contribute to its cost, the plan is not considered a group plan.

The COB provision does not apply to any individual or personal policies of insurance.

Special COB rules apply for management employees who retire on or after January 1, 1992 (See page 50).

Keep in mind, MAP PPO hospital and physician provisions apply even if MAP is the secondary plan.

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**It is your responsibility to notify your benefit office of any additions/changes in your and your dependents' eligibility for other insurance coverage.**

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### WHEN COORDINATION OF BENEFITS DOES NOT APPLY

When a person is covered under a Health Maintenance Organization (HMO), BellSouth does not provide secondary coverage. In addition, there is no COB between BellSouth Participating Companies covered under MAP. (For a list of Participating Companies, see inside front cover of this booklet.)

### PRIMARY/SECONDARY COVERAGE

The plan that considers expenses first is the **primary** plan. The plan that waits for the primary plan to consider expenses is the **secondary** plan.

When MAP is the secondary plan, combined benefits from both the primary and secondary plans may not total more than the amount MAP would have paid alone. In other words, MAP will coordinate benefits up to MAP benefit levels. Also, MAP will pay only benefits for expenses covered by MAP.

MAP coordinates with other group health plans according to the following rules:

- A plan that has no rules for coordinating benefits with other plans is primary.
- A plan that has a secondary-only rule for its employees when other coverage is available will be primary.
- A plan that covers a person as an employee or in some capacity other than as a dependent is primary.
- The plan of the parent or sponsor whose birthday comes first in the year will be the primary plan for children and other dependents. This is referred to as the "birthday rule". If a plan has not adopted the "birthday rule",

then that plan's rules will determine which plan is primary. However, if your spouse works and declines

Your spouse has surgery on March 1, 1991, and non-PPO surgeon's fees of $1,000 are within R&C limits and covered under both ABC's and BellSouth's plans. Your MAP deductible has been met. You do not live in a PPO area.

MAP's benefit level is 90%. ABC's plan benefit level is 80%; therefore, it would have paid $800 (80% of $1,000)

Once it has been determined which medical option to apply, benefits will be coordinated according to MAP's COB provisions.

### Example #4: Flexible Benefits

*Assume:*

Your spouse is an active employee of AB & Company (ABC) and works more than 30 hours per week. ABC's plan, therefore, is the primary plan.

Your spouse has surgery on March 1, 1991, and non-PPO surgeon's fees of $1,000 are within R&C limits and covered under both plans. Your MAP deductible has been met. You do not live in a PPO area.

MAP's benefit level is 90%. ABC offers your spouse three different medical options. Each one covers the same expenses but at different rates:

- Option 1 pays 70% of the covered expenses
- Option 2 pays 80% of the covered expenses
- Option 3 pays 90% of the covered expenses

Your spouse declines coverage under any option.

According to COB rules, MAP coverage is secondary. The mid-priced option, Option 2, will be used to determine MAP benefits as follows:

| | |
|---|---|
| MAP benefit (90% of $1,000) | $900 |
| ABC's Option 2 benefit (80% of $1,000) | -800 |
| MAP pays | $100 |

MAP pays $100 even though ABC's plan did not actually pay the $800, and the $800 does not apply toward the MAP deductible or out-of-pocket limit.

If your spouse had not declined coverage but had elected Option 1 or 2, MAP's benefit would still be $100 (according to the mid-priced option rule). If Option 3 had been elected, no MAP benefits would have been paid since Option 3's benefit level is the same as MAP's. **According to COB rules, MAP coordinates benefits only up to MAP levels.**

## SECTION 13. MEDICARE

There are two parts to Medicare: **Part A** provides benefits for hospital care, and **Part B** provides benefits toward physician's fees and certain other covered medical expenses.

Based on current federal law, you and your dependents may become eligible for both parts of Medicare upon reaching age 65, or before age 65 if you are disabled and have received 24 months of disability payments from Social Security. Medicare is also available at any age if the participant has End-Stage Renal Disease.

You should contact your local Social Security office for information on how to enroll in Medicare. Part A is paid in full by Medicare. For Part B, the government charges a monthly premium. However, the Company currently reimburses Part B premiums, up to the 1990 premium amount, excluding any special coverage premiums, that you and your eligible Class I dependents who were covered under MAP on your retirement effective date pay to the government for Part B coverage, unless the Company is providing primary medical coverage. You must be pension-eligible to receive Part B reimbursement. Long term disability (LTD) participants who are not service or disability pension eligible do not qualify for Part B reimbursement.

To apply for reimbursement, contact your Benefit Office. If the Company is providing primary coverage, Part B premiums are not reimbursed.

It is your responsibility to notify your Benefit Office of any change in Medicare eligibility for you and your dependents.

Once you or your dependents meet the criteria for Medicare eligibility, MAP will not reimburse any benefits payable under the law regardless of your enrollment status. MAP will subtract any benefits available under Medicare from the MAP benefits you can receive. In combination with Medicare, MAP currently provides the same level of coverage you had under MAP alone. Remember, the MAP deductible must be satisfied each calendar year. Expenses applied to the Medicare deductible may also be applied (used) to satisfy the MAP deductible. Medicare will be primary except as explained below.

### COVERAGE FOR ACTIVE EMPLOYEES & THEIR DEPENDENTS ELIGIBLE FOR MEDICARE

If you work beyond age 65, MAP will continue to be primary for you and your spouse. If either you or your spouse reject, in writing, primary coverage under MAP and choose Medicare as your primary coverage, MAP coverage will end for the person making the election until our employee retires.

For active employees who have a disabled dependent (for reasons other than End-Stage Renal Disease), MAP will provide primary coverage for the disabled dependent until he/she reaches age 65. At age 65, Medicare becomes the primary plan for any disabled dependent other than the spouse. The disabled spouse's coverage under MAP will remain primary as long as the participant is an active employee.

If a participant requires treatment for End-Stage Renal Disease, MAP will provide primary coverage for the first 18 months but will be secondary to Medicare thereafter.

### COVERAGE FOR SPOUSES AND CLASS II DEPENDENTS NOT ELIGIBLE FOR MEDICARE

For retirees whose retirement date is prior to January 1, 1988, spouses who have to pay for Medicare coverage due to their insufficient work record will not be carved-out under MAP. BellSouth will continue to provide primary MAP coverage until the dependent is eligible for Medicare coverage on the retiree's work records. Then, MAP will provide secondary coverage.

For retirees whose retirement date is on or after January 1, 1988, spouses who have to pay for Medicare coverage will be carved-out under MAP. Only secondary MAP benefits will be provided, even though the spouse has to pay for Medicare coverage due to an insufficient work history.

The carve-out will apply to all Class II dependents who become eligible for Medicare, regardless of their work history or the retiree's retirement date.

In states where appropriate agreements are in place, Medicare carriers will electronically file your claim for secondary coverage directly with MAP.

No reimbursement for Part B Medicare premiums will be made for Class II dependents.

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**The Company reserves the right to modify coverage, including reduction, elimination of coverage, or requiring employees or dependents to pay all or a portion of coverage costs, at its discretion, subject to applicable collective bargaining agreements.**

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